



IDAHO DEPARTMENT OF
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September 15, 2006

Debra Mills, Administrator
Nampa Care Center
404 North Horton Street
Nampa, ID 83651

Provider #: 135019

Dear Ms. Mills:

On **August 17, 2006**, a Complaint Investigation was conducted at Nampa Care Center. Marcia Key, R.N. and Lorna Bouse, L.S.W. conducted the complaint investigation. A total of 13 survey hours were required to complete this investigation. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00001695

ALLEGATION #1:

The complainant stated the identified resident is a diabetic and receives daily peritoneal dialysis due to renal failure. She requires a closely monitored special diet and blood glucose (BG) monitoring.

The facility was not giving the resident the required menu. The resident should not have apple juice, but it routinely comes on her tray. The dinner meal may consist of scrambled eggs, two pieces of white toast with jelly and cooked apples with sugar and cinnamon. The resident receives the incorrect menu items with resulting increased blood sugars.

FINDINGS:

The facility provided a menu for the current week. The menu included planned meals for both diabetics and dialysis patients. None of the meals for the week for any type of diet consisted of scrambled eggs, white toast with jelly or cooked apples with sugar and cinnamon for dinner.

Although, some of these items appeared on the breakfast menus. The menu did have some fruit that was specified a "renal" fruit and fruits for the low concentrated sweets (diabetic diet) were measured for the daily allowance.

The dietitian consultant was interviewed regarding the menus and what was provided for the resident. She indicated the resident received a "Renal Diabetic" diet as ordered by the physician. This was confirmed by review of the current physician's orders. The dietitian also stated that it was possible that at one time or another staff could have given her apple juice, as mistakes could be made. The dietitian stated, "We do our best to meet her dietary needs. We offer her other things if she does not like the planned items."

The facility experienced some cooking equipment problems on the day of the complaint survey. The dietitian provided a substitute menu for the lunch meal. The substitute meal was provided at lunch to the identified resident. The resident also had a cup of hot chocolate prior to her meal. The resident told the surveyor the drink was sugar free. The resident was observed in her room and had two glasses of fluid on the over bed table. The resident said the fluids were tea. She did not confirm that she was routinely getting apple juice.

The resident was capable of telling staff if she received an item which she did not want, as was observed during the lunch meal on August 17, 2006.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated the resident had no peritoneal infections while she was performing her own dialysis at home, but since her admission, she has had repeated infections. The complainant does not know the source of the infection because during the dialysis, only staff is allowed in the room.

FINDINGS:

The resident has had two peritoneal infections since she was admitted to the facility. The first infection occurred when the resident was performing her own dialysis treatment, as she had prior to admission. The staff assisted only with the preparation. At the time of the second infection staff was performing the dialysis. The resident attended outside activities on most Sundays. The resident/family performed the dialysis during extended times out of the facility. The source of the second infection, therefore, could not be determined.

On August 17, 2006, the surveyor observed a nurse performing the peritoneal dialysis. The surveyor did not observe any breach in infection control. The nurse indicated that each nurse who performs the dialysis is qualified to do so.

The staff development coordinator provided evidence that the nurses received inservice presented by the nurse from a Nephrology Center two years ago and again when the identified resident was admitted to the facility. One to one inservice was conducted and the instructing nurse is currently available by telephone for questions.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident has not been receiving the required/ordered daily physical therapy and is getting very weak. The complainant was not sure if the resident had refused the sessions.

FINDINGS:

The resident's physical therapy records were reviewed. The resident declined therapy only two times in two months. The resident missed therapy two additional times in two months due to appointments outside the facility. The therapy assistant scheduled a time for the resident's therapy on August 17, 2006, while the surveyor was in the room with the resident. The therapy assistant was later interviewed. She stated the resident was very motivated because she wanted to be discharged as soon as possible. The therapy assistant stated the resident's abilities varied at times. She indicated that one day the resident could walk unassisted and the next day she could perform transfers only with assistance. The therapy assistant said her performance depended on her physical well being at the time.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant stated the resident fell out of bed when she attempted to stand and walk in her room to relieve her restless leg syndrome. This occurred in late July or early August, 2006. The resident could not get up from the floor. Staff needed to use a lift. While she was being returned to bed, she heard and felt a pop in her left arm region. Several days later a family member noticed the resident's arm was very swollen. During a scheduled appointment the resident's physician was told about the fall. An x-ray revealed a fractured clavicle. The resident had an ultrasound and will need to be seen by an orthopedic specialist to see if surgery is needed.

FINDINGS:

The investigation findings for this incident were reviewed. The incident occurred on the night

shift on August 2, 2006. The incident was witnessed by staff. Staff interviews were documented. The report documented the resident did not fall out of bed but rather went to her knees when staff were attempting to transfer her. The staff used a Sara lift to help the resident stand. While in the standing position she suddenly went limp, catching her arm on one of the Sara lift straps. The resident sustained a bruise under her arm.

The resident had a routine doctor's appointment on August 7, 2006. The resident told the physician about the fall and that her arm hurt. An X-ray revealed a fractured clavicle.

The resident was interviewed and stated she had injured her arm while staff was using a lift to "hoist" her up. She stated that she was not going to have surgery. She was observed with a sling on her left arm, and she was leaning against her left arm with her hand on the bed. She did not appear to be in any pain. She told the surveyor she needed help to put her clothes on as she could not raise her arm up high without discomfort.

The injury was not the result of staff error.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The complainant stated she was not sure if the family or physician was notified of the fall.

FINDINGS:

The incident and accident report documented the staff notified a family member and the resident's physician on the morning of August 3, 2006.

CONCLUSIONS:

Unsubstantiated. Allegation did not occur.

ALLEGATION #6:

The complainant stated that the resident has been having increased blood sugars. Staff says they can just give the resident a sliding scale dose of insulin, instead of correcting the problem. In addition, staff is sometimes taking the BGs after the resident eats instead of before she eats. The resident then has an increased dosage of insulin administered and the BGs drop. The resident's dialysis fluid type is based on the results of the BGs which do not reflect an accurate picture because of the times BGs are taken. She has been retaining more fluid to the point that one day the complainant noticed the resident's arm weeping from the retained fluids. This occurred about the mid-end of July, 2006.

FINDINGS:

The current physician's orders directed that the resident was to receive insulin twice daily and also a "sliding scale" insulin coverage, based on the results of her blood glucose levels. There was also an order to test BGs as needed for signs and symptoms of hypo/hyperglycemia, as well as the routine checks before meals and at night.

A nurse was interviewed. She stated staff performs the BG tests before the resident's meals. There were many times the BGs were also tested after her meals. This depended on the results of the before meal BGs and her symptoms. The sliding scale insulin would be administered based on the post meal BGs. She also stated the resident makes the determination as to the type of dialysate solution to be used during each dialysis. This determination is based on how she feels at the time and how much fluid her body is retaining. The physician's orders verified the resident was allowed to decide the dialysate solution.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

A handwritten signature in cursive script that reads "Marcia Key for".

MARCIA KEY, R.N.
Health Facility Surveyor
Long Term Care

MK/dmj